Home-based primary care in Canada

Five innovative urban practices

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Abstract

Problem addressed While the home-based primary care model offers potential patient and system-level benefits, implementation of interprofessional home-based primary care teams has not been widespread. When caring for homebound patients, family physicians are often not included as regular contributors or participants in the team that coordinates and plans much of the care for these patients.

Objective of program To describe a selection of home-based primary care practices and to identify barriers to and facilitators of the creation and sustainability of these models within the publicly funded health care system.

Program description Five existing home-based primary care practices were examined: 1 each in Victoria and Vancouver in BC; 1 in Winnipeg, Man; and 2 in Toronto, Ont. The research team conducted semistructured team interviews, interviews with the physician leads, and informal observation of elements of team-based care planning at these 5 sites. From these sources, descriptions of each practice were developed in terms of practice history, context, and initiating factors; practice goals and performance management; and practice design elements, including target population, referral sources, and team composition. A qualitative thematic content analysis was used to extract and distil implementation barriers and facilitators across the 5 practices. Members of each practice team validated the interpretation of thematic information. Substantial heterogeneity was found in the composition of the interprofessional teams. The overarching initiating factor for the home-based component of all practices could be described as identifying and addressing unmet community need. Physician leadership, creative funding models, team camaraderie, and community partnerships were the main facilitators. Limited health system support, geography, and lack of existing models of care were the main barriers.

Conclusion Substantial barriers to wider implementation of home-based primary care practices persist. Examination of existing practices identifies the importance of physician leadership and commitment to meeting community need.

Editor's key points

- As the Canadian population ages, the demand for community-based and home-based care provision is expected to increase; however, substantial barriers to wider implementation of these practices exist.
- An examination of 5 primary care practices providing care to homebound patients in Canada identified common barriers to the creation and sustainability of these models within the publicly funded health care system, such as geographic considerations, high levels of administrative oversight, and inflexible policies. Key facilitators included physician leadership of the team, partnerships with other agencies, tools and processes that support communication among team members, and provider-patient relationship building.
- Provision of home-based primary care requires intensive investment in team structure and processes as well as allowances for creative problem solving. The intensity of the work requires smaller patient panels and prioritization of the patient-provider relationship. Sustainable funding models and tools that support communication among team members are needed to bolster these services and expand the delivery of home-based care.

Canada is facing an aging population and, with it, changes in the demand for community-based and home-based care provision.[1] People aged 65 and older and those aged 80 and older represent growing proportions of the population, and many of these individuals have complex, chronic comorbidities.[2] Additionally, it is estimated that between 8% and 10% of community-dwelling individuals older than 65 are homebound (eg, do not leave their home at least once per week) owing to physical, psychiatric, or social limitations.[3] Accessing regular primary care continues to be a challenge for the general population[4] but is an even greater challenge for individuals who are homebound.[5]

In primary care, the concept of the Patient's Medical Home describes team-based, accessible, coordinated, and connected care for patients led by family physicians.[6] This model works well for most, but what about homebound

patients who are unable to get to their doctors' offices? Home-based primary care, a model of care that provides continuous, comprehensive, patient-centred care via an interdisciplinary team that provides care in a patient's home, is required to meet the needs of frail older adults.[7,8]

Research evidence is incomplete regarding the impact of home-based primary care on patient outcomes, providers, and the health care system. This body of literature is complicated by variation in elements of home-based service design (eg, length and continuity of service, composition of interdisciplinary teams) and discrepancies around how best to define the effectiveness and impact of home-based primary care (eg, acute care avoidance, patient experience, cost-effectiveness, caregiver satisfaction, etc). Dhalla et al demonstrated that short-term home-based services for patients following discharge from hospital that lack ongoing continuity are not effective in reducing emergency department visits.[9] However, a systematic review conducted by Stall et al looking at home-based, continuous, long-term primary care highlights improvements in patient quality of life, caregiver satisfaction, reduction in emergency department visits, hospitalizations, readmissions, and long-term care admissions.[7,8] Rosenberg showed a similar benefit in outreach services for homebound elders in a Canadian setting,[10] and Sinha endorses the support for and growth of house calls as a model that has been clearly demonstrated "to deliver improved patient satisfaction, quality of life, and patient outcomes."[4] The COVID-19 pandemic amplified the need to manage seniors' health issues at home in the community whenever possible.[11]

While the home-based primary care model offers potential patient and system-level benefits,[12,13] implementation of interprofessional home-based primary care teams has not been widespread. An improvement in billing codes has led to a more supportive climate for home visits in Ontario,[14] but this situation has not been replicated in other provinces.

A review of recent literature finds descriptions of small numbers of primary care teams that endeavour to at least partially address unmet needs of homebound frail older adults.[15] However, family physicians are often not included as regular contributors or participants in teams that coordinate and plan much of the care for homebound patients.[16]

In this study we describe 5 existing Canadian primary care practices that aim to address the needs of homebound patients via interprofessional teams that provide house calls. In describing these existing practices, we seek to inform future development and broader implementation of similar services.

Program objective

The objective of this study was 2-fold: to describe a selection of home-based primary care practices in Canada and to explore the barriers and facilitators that contribute to the extent to which each practice has become a supported, sustainable model of care within the publicly funded health care system. Ethics approval for this study was obtained from the Research Ethics Board at the University of Manitoba in Winnipeg.

Program description

Drawing from Stall et al,[7] we adopted the following criteria to define a home-based primary care practice: longitudinal primary-care relationship with care delivered in the home; management of both chronic diseases and social issues; interprofessional teams led by a primary care provider; partnership with existing home health services; and practice goals that include improving access to primary care and reducing episodic use of acute care.

Through our professional network we identified 5 urban practices that fit our criteria: 1 each in Victoria and Vancouver in BC; 1 in Winnipeg, Man; and 2 in Toronto, Ont. Practices were contacted by e-mail and invited to participate in a site visit from the researchers. We conducted 4 site visits in person and 1 via videoconferencing. Site visits consisted of an interview with the team leader or leaders, a team interview, and an informal observation of the elements of team-based care planning (when feasible). Interviews followed a semistructured guide that included sets of questions about practice history, context, and initiating factors; practice goals and performance management; practice design elements (including target population, referral sources, and team composition); and implementation barriers and facilitators. Team interviews were audiorecorded (with consent) and transcribed; additionally, field notes were taken during observation of team-based care planning. Interview transcripts and researcher field notes became the basis for our descriptive summary and thematic content analysis.

Our results offer a descriptive summary of responses to the first 3 sets of questions listed above, highlighting key similarities and differences across practices. For questions about implementation barriers and facilitators, we pursued a qualitative thematic content analysis[17,18] to identify and describe themes for both implementation barriers and facilitators. Two researchers (A.C., T.S.) began by reading through all transcripts and field notes, recording impressions and possible themes. Researchers (A.C., T.S.) independently identified codes and then met several times to discuss the evolving coding scheme. Once the coding scheme was developed, all barrier- and facilitator-relevant content was extracted and coded independently, and discrepancies were resolved by consensus. As barrier and facilitator themes emerged, interpretations were discussed by the full team. Data were organized in a theme-by-practice matrix to facilitate the synthesis of within-practice examination (case analysis) and comparison across practices (cross-case analysis) of themes. Members of each practice team validated the interpretation of thematic information.

Results

Practice description. Our results highlight the most notable commonalities and differences across the practices in terms of practice history, context, and initiating factors; practice goals and performance management; and practice design elements, including target population, referral sources, and team composition. **Table 1** summarizes each of these components for each practice as a way to facilitate cross-practice comparisons.

Practice history, context, and initiating factors: For each of the 5 practices, home-based primary care visits had been initiated relatively recently, and the first generation of providers was still in place. Team leaders reported that identifying and responding to a community need led to the creation of the home-based component of their practice. Responding to a funding cut in geriatric assessments; anticipating a gap in service owing to retirement of a community physician with a primarily homebound practice; and responding to challenges with complex discharges from hospital are examples of this. All teams described the difficulty that patients had in accessing home-based primary care as a key motivator of their work. In each jurisdiction the teams knew of only 2 or 3 other family physicians who provided home visits.

The practices differed regarding their degree of focus on home-based primary care. Sites 1, 4, and 5 solely focused on home-based primary care and did not provide any office-based care. At sites 2 and 3, home-based primary care was only part of the services they provided, with most of their focus being on office-based and hospital-based care. Thus, sites 2 and 3 had substantially smaller panels of home-based patients. Additionally, sites 2 and 3 were full-time teaching sites for family medicine residents.

Practice goals and outcome measurement: Practices varied in their measures of quality and effectiveness. Emergency department visit rates, hospital admission rates, and hospital length of stay were measured by 4 of the 5 practices. Rates were compared prior to enrolment with their practices (usually 6 months to 1 year) to a similar time frame after enrolment. Additional indicators included hospital readmission rate (1 of 5 teams), caregiver stress (1 of 5 teams), patient death at home (1 of 5 teams), patients' functional status (1 of 5 teams), and patient-reported health (1 of 5 teams).

Practices varied in their capacity for outcome measurement. One practice had a research assistant to provide ongoing support; the sustainability of data collection was described by most other teams as a substantial challenge. Outcome measurement was described as a supported priority in the initial stages of implementing their teams; however, once the teams had been launched, ongoing outcome measurement was not maintained.

Practice design elements: There were differences among the practices in the specific patient population served, referral sources, and team composition.

Regarding targeted patient populations, 3 practices identified minimum age and *homeboundedness* as intake criteria; 2 practices specifically identified high hospital use as an intake criterion. Each practice had specified geographic boundaries—either all or a specified portion of a city.

Referral sources varied; home care and local hospital referrals were common to all practices. One practice accepted self-referrals from patients. Referrals from other community-based primary care providers were minimal across all programs.

Table 1. Practice descriptions

CHARACTERISTIC	VICTORIA (SITE 1)	WINNIPEG (SITE 2)	TORONTO (SITE 3)	VANCOUVER (SITE 4)	TORONTO (SITE 5)
Initiating factor	Funding cuts to geriatric assessment services	High hospital use and difficult discharges	High hospital use and difficult discharges	Community need of homebound patients with retiring physician	Funding cuts to home-care services for seniors
First year	2003	2011	2011	2008	2007
Performance metrics	• ED visits • Hospital days	• ED visits • Hospital days	• ED visits • Hospital days	• Deaths at home	• Hospital admissions • Hospital days
Target patient population	• Homebound • Age >75 y • Frail	• Adults with high hospital use	• Homebound • Age >65 y • Adults with high hospital use	• Homebound • Age >80 y	• Homebound • Age >65 y • Frail
Approximate panel size	280	85	68	400	300
Referral source	• Self-referrals • Home care, about 25% • Community physician, about 25% • Hospital	• Home care • Local hospital	• Home care • Local hospital	• Home care	• Hospital, 40% • Home care, 40% • Other, 20%

ED—emergency department.

There was significant diversity among teams in size and composition (see **Table 2**). Physicians and nurses were integral members on all 5 teams. Nurse practitioners worked in 4 of the 5 practices; their work was described as clinically similar to that of the physicians. Dedicated physician time for clinical involvement varied across the practices; regardless, across all practices, physicians filled the role of team leader and were involved in creating the team, securing funds, and providing ongoing leadership. A number of unique positions were also described: recreational therapist, physician assistant, mental health counselor, research coordinator, and *multi-skilled worker* (who performed various tasks such as conducting check-in visits, delivering groceries, and providing patient transportation).

All practices described partnerships with other programs—in particular, regional home-care programs. The degree of partnership varied; 2 practices had home-care staff integrated into the team. More often, partnerships with home-care programs entailed referrals, collaboration on care plans, joint home visits, and case conferencing. Additional partnerships described included mental health programs, income support services, long-term care homes, and local hospitals.

Implementation barriers and facilitators

Barriers: Content analysis resulted in identification of 13 barriers (see **Table 3**). The 2 most substantial barriers that were identified by all 5 teams were geography and leadership environment. In terms of geography, teams described negative effects on work flow and productivity owing to the need to travel long distances to attend certain home visits. Additionally, the (sometimes arbitrary) geographic boundaries limited admission to the service, creating inequities in access.

Teams often referred to the external leadership environment as a barrier when discussing support for their work within the wider health system. Teams pointed to high levels of leadership oversight, which was at times described as bureaucracy, and thought that it affected both physician engagement and team function. For example, team meetings were viewed internally as a good opportunity for case discussions and interprofessional collaboration, but administration (external leadership) often saw these meetings as resource intensive and questioned their cost-effectiveness:

> And we found [team meetings] to be helpful and useful on a couple of levels to bringing all of the team together, but we are decreasing that now. We're cutting back on that now to twice a month maybe or maybe once a month, [because] we're getting pressure to do that. (Site 3)

Four of the 5 teams described tension between existing policy and the need to provide individualized home-based care. Specifically, as teams identified the complex needs of their patients, they found it necessary to adapt their care approach to meet patients' needs. This flexible, patient-centred provision of care was sometimes at odds with existing policies, which generally tended to favour more uniform provision of services. This disconnect led to an element of frustration among care providers.

Facilitators: Content analysis yielded 11 facilitating factors described as integral to the success and sustainability of the practices (see **Table 3**). There were

Table 2. Interdisciplinary team composition at each practice

ROLE	VICTORIA (SITE 1)	WINNIPEG (SITE 2)	TORONTO (SITE 3)	VANCOUVER (SITE 4)	TORONTO (SITE 5)
Physician	1.7	0.3	0.4	3.0	4.0
Nurse practitioner	NA	1.0	0.3	2.0	2.0
Physician assistant	NA	NA	1.0	NA	NA
Registered nurse	2.0	1.0	3.0	3.0	NA
Manager	0.2	0.2	0.2	0.2	1.0
Occupational therapist	NA	NA	NA	1.0	3.0
Physical therapist	0.5	NA	NA	1.5	0.5
Rehabilitation aide	1.0	NA	NA	2.0	NA
Pharmacist	NA	0.2	NA	NA	NA
Multi-skilled worker	NA	1.0	NA	NA	NA
Counselor	NA	NA	1.0	NA	NA
Home-care coordinator	NA	2.0	1.0	NA	1.0
Total FTE	**5.4**	**5.7**	**6.9**	**12.7**	**11.5**

FTE—full-time equivalent, NA—not applicable.

4 facilitators that all 5 teams identified as being critical. Specifically, these critical facilitators were physician leadership of the team; partnership with other agencies; tools and processes that support communication among team members; and provider-patient relationship building.

Physician leadership on 3 different levels was identified by all teams as integral to both the initial implementation of their programs and their ongoing sustainability. On a system level, teams described physicians as being central not only to initiation of services at every site and the bringing together of various team members but also to connections across programs (ie, from hospital to community and primary care to home care). For example:

> We still wanted to provide the same service so that is why I then pushed the hospital to match it and got funding for the physician assistant dedicated to that

Table 3. Barriers and facilitators to change at each practice (ie, developing, implementing, and sustaining team-based care of homebound patients)

BARRIER OR FACILITATOR	VICTORIA (SITE 1)	WINNIPEG (SITE 2)	TORONTO (SITE 3)	VANCOUVER (SITE 4)	TORONTO (SITE 5)
Barriers					
• Limited health system leadership support	X*	X	X	X	X
• Geography	X	X	X	X	X
• Obstructive regional or system-level policy		X	X	X	X
• Lack of clarity of referral criteria		X	X	X	X
• Tension with pre-existing PCPs		X	X	X	X
• Limited capacity for data collection		X	X	X	X
• Lack of existing models of care		X	X	X	
• Lack of consistent funding	X	X	X		
• Limitations in linking patient records across team providers (eg, charting in different EMR programs)		X	X	X	
• Staff inconsistency (turnover, vacation)			X	X	
• Difficulty transitioning patient off service		X	X		X
• Too many administrative tasks			X	X	
• Insufficient time				X	
Facilitators					
• Physician leadership	X	X	X	X	X
• Partnership with other agencies	X	X	X	X	X
• Tools and processes to support communication	X	X	X	X	X
• Provider-patient relationship building	X	X	X	X	X
• Team camaraderie	X	X	X	X	X
• Creative funding	X	X	X	X	X
• Acute care and community partnership	X	X	X		X
• Broad scope and experience of provider team	X		X		X
• Patient-family physician attachment (medical home)	X	X	X	X	X
• Bending the rules		X	X	X	
• Social connection offered by various team members		X		X	

EMR—electronic medical record, PCP—primary care provider.
*X denotes that the barrier or facilitator is present.

> program. Then I told them to match it with a PA [physician assistant] or experienced nurse. (Site 3)

Physicians continued to provide administrative leadership on a day-to-day basis (eg, chairing team meetings). In addition to providing clinical services themselves, physicians provided clinical leadership and supported other team members in their work:

> My title is a PA (physician assistant). This program right now has 4 physicians and I see the patient at home and if I need help, I will call [the physicians] or message them if they are busy. All of them, 4 of them, they are very good to take my messages and if I call them, they answer my phone calls. (Site 3)

While there were nurse practitioners at 4 of the sites and a physician assistant at 1, physicians continued to be the most responsible providers for all or most of the patients at every site.

Integration within the larger health care system occurred along a continuum—from an independent team to teams directly operating in connection with local hospitals. In addition to hospitals and acute care services, other partners included home care programs, housing services, addictions services, and palliative care programs.

Tools and processes that support communication were also identified as important across all teams and included such things as regular meetings, direct telephone calls from team members to one another, e-mail and text messaging, and documentation within a shared record.

Finally, all 5 teams spoke about the importance of provider-patient relationship building. A trauma-informed approach was described as critical to working with a homebound population; it was stated that without the development of trust, high quality of care for this population cannot be realized.

Two additional facilitators were noted by 4 teams: team camaraderie and creative funding. Teams highlighted developing and nurturing relationships among team members as being essential to caring for patients within this model; ensuring time together as a team was imperative. *Creative funding* was described as necessary to support these home-based primary care models; at sites 1 and 4, physicians operated on fee-for-service funding. At sites 2 and 3, physicians were remunerated on time-based contracts. Home visit portions of their practices were small parts of larger general practices. At site 5, some physicians operated on a fee-for-service basis while others had time-based contracts. Nonphysician funding was similarly diverse:

> Three different community agencies donated human resource[s]—nurse, OT [occupational therapist], SW [social worker]—2 days per week to work. (Site 5)

At site 1, nonmedical services were paid for out of fees paid by patients. At sites 2 and 4, nonmedical staff were funded by single government programs in their respective provinces. At sites 3 and 5, the teams were slowly pulled together from funding provided by different community partners. At the time of the study, most of the funding was provided by individual government programs in each case, but there were some contributions from provincial home-care and community health agencies; each site identified that the impetus to pull the teams together came from the teams themselves and that the physician leaders were integral advocates in this journey.

Discussion

This study describes 5 innovative urban Canadian primary care practices that provide home-based, comprehensive primary care via interprofessional teams. We found that in Canada, primary care for homebound patients does not receive broad system support, making it challenging to successfully implement, effectively evaluate, and sustain models of care for homebound patients. Individual physician impetus seems to be a key component of launching and maintaining such models.

A consistent message was heard across the 5 practices: although teams aimed to meet individual patients' needs, this work was often done in a broader setting of existing policies that are not completely aligned with patient-centred care. Provision of home-based primary care requires intensive investment in team structure and processes as well as support for creative problem solving and partnership across sectors. The intensity of the work requires smaller patient panels and prioritization of the patient-provider relationship. Relationship building and trust are integral not only to patient care but also to team dynamics; time must be allocated to account for this component of home-based primary care models. Additionally, there is a need to develop funding models that sustainably fund both physician and nonphysician team members and to provide tools to support communication among team members.

Despite the common themes identified among these practices, it is clear that one size does not fit all in responding to the needs of homebound patients. This descriptive study serves as a first step toward identifying the contextual elements of home-based practices in Canada. It is noteworthy that home-based primary care is being provided via a variety of care models in the urban context. The teams we studied used different funding models and included teaching and nonteaching practices, and some practices focused solely on home-based care while others that included it as part of larger general practices.

It is important to note that the teams interviewed for this project were selected from a known collegial network of urban teams, and thus findings might not be

entirely generalizable. The fact that all 5 practices were led by physicians who were engaged in a national network was a positive facilitating factor, but we have less information from jurisdictions that did not have similar physician leadership, and it might be difficult to reproduce similar results in such a jurisdiction. Additionally, we sought input only from the teams themselves; further insights would surely have been gained by consulting relevant system administrators, rural teams, patients, and caregivers.

Conclusion

Models of primary care for homebound patients, like the population they seek to serve, are often not prioritized in the health system. Adapting models of care to support patients in the community is key to long-term sustainability of our health care system. Interprofessional teams are essential to ensuring the comprehensive care needed to support these patients, and their caregivers, in their homes is available. The success of these new models lies in engaging physicians and other health care professionals in the development and sustainability of the models. Success also requires ensuring leadership is supportive of the clinical and nonclinical components of the work and is willing to facilitate appropriate remuneration and accommodate the adaptiveness needed for appropriate patient-centred care. Future work in this area needs to support development of policies that ensure partnership and collaboration across sectors to prioritize care for homebound patients with complex care needs and their caregivers.

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Contributors

Drs Amanda Condon and **Paul Sawchuk** conducted 4 of the interviews while **Dr Tara Stewart** conducted the fifth interview. **Drs Condon** and **Stewart** conducted the thematic content analysis. All 3 authors shared in preparing the manuscript.

Competing interests

None declared

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